MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

December 13-14, 2001

Updating payments for outpatient dialysis services for 2003

ISSUE: Is Medicare's policies appropriate for paying for outpatient dialysis services delivered by dialysis facilities? Should payments for outpatient dialysis services be updated for 2003?

KEY POINTS: Medicare's payment rate for composite rate services averaged two and four percent less than the costs incurred by freestanding dialysis facilities in 1999 and 2000, respectively. However, Medicare's payments exceeded providers' costs by about seven percent in 1999 when we considered payments and costs for both composite rate services and separately billable drugs. Other information about payment adequacy shows that:

- The growth in the number of dialysis facilities has kept pace with the growth in the number of dialysis beneficiaries.
- Providers' costs in furnishing composite rate services has increased by about the same rate as costs predicted by the dialysis market basket between 1997-2000.
- The use of separately billable drugs administered during dialysis has increased throughout the 1990s and payments for these services represented about 30 percent of Medicare's total payments to dialysis facilities in 1999.
- Beneficiaries appear to be obtaining access to needed dialysis services. Quality of dialysis care, as measured by dialysis adequacy and patients' anemia status, continues to improve.

ACTION: Commissioners should discuss the findings presented in the attached memo. Specifically, Commissioners should discuss whether: 1) current base payment rates are adequate, and 2) whether the composite rate should be updated for 2003. The Commission's recommendation about updating payments for dialysis services will be included in the March 2002 report.

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MEETING BRIEF

December 13-14, 2001

Controlling spending for physician services without the sustainable growth rate system

ISSUE: The sustainable growth rate (SGR) system is Medicare's method for updating payments for physician services. The system has two goals:

- update payments to account for changes in the cost of providing physician services, and
- control spending for physician services by basing updates on an expenditure target.

These two goals are incompatible. Because actual spending for physician services is unlikely to be the same as the target, updates under the SGR system can lead to payments that diverge from costs. If this occurs, payments will either be too low, potentially jeopardizing beneficiary access to care, or too high, making spending higher than necessary.

This problem and others have led MedPAC to recommend that the Congress replace the SGR system. At issue is whether the Congress and the Secretary can control spending for physician services without a mechanism like the SGR system.

KEY POINTS: Controlling spending means controlling its two components: payment rates and the quantity and intensity of services. With prospective payment systems, controlling payment rates occurs through updating payments. If the current level of payments is too high, the update should be less than the expected change in costs. On the other hand, if the current level of payments is too low, the update should be greater than the expected change in costs.

Controlling the quantity and intensity of services is more difficult. Both dimensions of service use are influenced by several factors, including changes in technology, beneficiaries' preferences, and diffusion of new care standards. Controlling physician services is more difficult still because physicians, in acting as an agent or advocate for their patients, have an incentive to provide more services.

Options for controlling the quantity and intensity of physician services include reducing fraud and abuse and reducing overuse of services. Compared to the SGR system, however, these strategies are likely to have a smaller impact on spending, at least in the short term.

ACTION: In the March report, the Commission should recommend a replacement for the SGR system. The new update system should account for payment adequacy and for changes in input prices. Controlling spending should be handled separately (see attached). A paper on assessing payment adequacy was discussed at the November meeting. A paper for the December meeting, separate from this one, addresses changes in input prices for physician and other services.

Based on discussion at the December meeting, staff will revise this paper to make it text box in the draft chapter on updating payments in traditional Medicare.

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